AHIMA Distance Education
Career-building Resources

Coding Neoplasms

Audio Seminar / Webinar

April 12, 2007

Practical Tools for Seminar Learning

Disclaimer

The American Health Information Management Association makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. AHIMA has no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this audio seminar, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this program. AHIMA makes no guarantee that the use of this program will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

As a provider of continuing education the American Health Information Management Association (AHIMA) must assure balance, independence, objectivity and scientific rigor in all of its endeavors. AHIMA is solely responsible for control of program objectives and content and the selection of presenters. All speakers and planning committee members are expected to disclose to the audience: (1) any significant financial interest or other relationships with the manufacturer(s) or provider(s) of any commercial product(s) or services(s) discussed in an educational presentation; (2) any significant financial interest or other relationship with any companies providing commercial support for the activity; and (3) if the presentation will include discussion of investigational or unlabeled uses of a product. The intent of this requirement is not to prevent a speaker with commercial affiliations from presenting, but rather to provide the participants with information from which they may make their own judgments.

Faculty

Kathleen E. Wall, MS, RHIA, CPUR

Kathleen is a Project Manager with 3M Consulting. She has 30 years of experience in Health Information Management, including coding and data quality. Kathleen is responsible for coordinating and managing DRG ASSURANCE projects, coding validations, Compliance Coding Audits and Audit Expert services.

During her career she has developed, initiated a process for and maintained quality of coded/DRG data for a 5 hospital system in Orlando, FL leading to 98% ongoing coding/DRG accuracy as well as demonstrating additional revenue for the hospitals. Participated in development of client services for Audit Expert software system with positive outcomes and facilitated client satisfaction with the product. Has performed compliance audits related to OIG-initiated audits and self-disclosures.

Ms. Wall belongs to AHIMA and the Florida Health Information Management Association. She has written articles for state newsletters. Kathleen is a Certified Professional in Utilization Review (CPUR). She holds a Master of Science Degree in Health Services Management, from Florida Institute of Technology, in Orlando and a Bachelor of Science in Health Information Management, from the University of Central Florida.

Lisa Kozakoff, RN, CPUR

Lisa is a Project Manager with 3M Consulting. She has more than 20 years of experience in healthcare, including extensive experience in critical care and all areas of surgery including open heart, vascular and general surgery. She has conducted over 200 physician presentations related to ICD-9-CM coding and documentation in the medical record and the impact to the 3M™ APR DRG System. Lisa is responsible for coordination and management of all client relations and on-site project activities, including team management, educational sessions and executive meetings. She currently manages and oversees delivery of all our APR DRG engagements and works with clients to analyze and interpret their monthly data to measure program impact.

Her previous experience includes being a Senior Consultant of a national consulting firm, and Director of Surgical Services; where she developed and implemented a pediatric Liver Transplant Program, as well as a multi-specialty laser program; responsible for staff training, quality assurance monitoring, disaster planning and daily operations.

Ms Kozakoff is a certified in Utilization Review (CPUR) and a Registered Nurse in the State of Georgia

Audrey G. Howard, RHIA

Audrey is a Senior Consultant with 3M Health Information Systems, Consulting Services (3M HIS/CS). She has consulted on numerous healthcare engagements nationally involving coding validations, coding education, coding process improvement, quality and compliance reviews as well as participating in the delivery of 3M's concurrent DRG ASSURANCE™ program. She is responsible for performing coding research and providing support for client coding questions. Audrey resides on 3M HIS/CS coding roundtable and also contributes to 3M HIS/CS Quarterly Newsletter. In addition, she researches and develops numerous training materials and manuals. Audrey also authors coding columns in the *For the Record* publication.

Audrey has over 16 years of experience in Health Information Management. During her professional career, she has functioned as a coder, senior DRG technician, coding supervisor, assistant director of a Health Information Management Department and consultant. Her duties

CONTINUED →

as assistant director included daily operations, managing bill hold, educating coding staff, and supervising release of information. As assistant director, she also computerized the coding process and streamlined the workflow. Her teaching experience includes advanced coding classes and documentation programs related to reimbursement, coding, compliance, severity and risk profiling. Audrey has worked with very large university hospitals, as well as multi-hospital systems to implement documentation improvement programs.

Audrey is a Registered Health Information Administrator. She earned her Bachelor of Science degree in Health Information Management from the University of Kansas in Lawrence, Kansas.

Table of Contents

Objectives

- **Discuss clinical information related to neoplasms**
- **Review neoplasm terminology**
- **Review the official ICD-9-CM coding guidelines related to neoplasm coding**
- **Apply ICD-9-CM diagnostic guidelines to neoplasm case studies**

1

Cancer – Clinical Information

- **Group of diseases characterized by uncontrolled growth and spread of abnormal cells**
- **Can develop from any tissue within any organ**
- **Cells grow and multiply**
- **Forms a mass of cancerous tissue that invades a nearby tissue and can spread throughout the body**

2

Cancer – Clinical Information

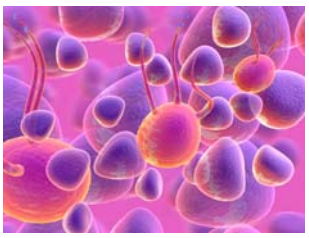
- **Transformation: process of cancer cells developing from normal cells**
  1. **Initiation – change in cell's genetic material caused by a carcinogen**
  2. **Promotion – a cell that has been initiated becomes cancerous**

- **Carcinogen – substances that can cause changes that can lead to cancer**
  - **Examples:**
    - **Chemical**
    - **Virus/Infectious agents**
    - **Radiation**
    - **Sunlight**
    - **Industrial processes**
    - **Occupational exposures**
  - **Carcinogens do not cause cancer in every case, all the time**

3

Cancer – Clinical Information

- **A cancer cell is a cell whose biologic function has been altered in such a way that it doesn't respond to the body's normal mechanisms for controlling cell growth and reproduction**
- **Abnormal cells continue to grow and result in cancer**
- **Even if a cell becomes cancerous, it can be destroyed by the immune system**



4

Facts About Cancer

- **About 1,444,920 new cancer cases are expected to be diagnosed in 2007**
  - **Estimate does not include carcinoma in situ of any site except urinary bladder and does not include basal and squamous cell skin cancers**
- **More than 1 million cases of basal and squamous cell skin cancer are expected to be diagnosed in 2007**
- **About 559,650 Americans are expected to die of cancer in 2007**
  - **Equates to more than 1,500 people a day**
- **Cancer is the second most common cause of death in the US (exceeded only by heart disease)**
  - **In the US cancer accounts for about 1 of every 4 deaths**
- **10.5 million Americans live with a history of cancer (as of January 2003)**

Information obtained from the American Cancer Society

5

Facts About Cancer

2007 Estimates - Male

Site of Cancer	Estimated New Cases		Estimated Deaths	
Prostate	218,890	29%	27,050	9%
Lung & Bronchus	114,760	15%	89,510	31%
Colon & Rectum	79,130	10%	26,000	9%
Urinary Bladder	50,040	7%	9,630	3%
Non-Hodgkin Lymphoma	34,200	4%	9,600	3%
Melanoma	33,910	4%	Not Reported	
Kidney & Renal Pelvis	31,590	4%	8,080	3%
Leukemia	24,800	3%	12,320	4%
Oral Cavity & Pharynx	24,180	3%	Not Reported	
Pancreas	18,830	2%	16,840	6%
Liver & Intrahepatic bile duct	Not Reported		11,280	4%
Esophagus	Not Reported		10,900	4%
All Sites	**766,860**	**100%**	**289,550**	**100%**

Excludes basal and squamous cell skin cancers and carcinoma *in situ* except urinary bladder

6

Facts About Cancer

2007 Estimates - Female

Site of Cancer	Estimated New Cases		Estimated Deaths	
Breast	178,480	26%	40,460	15%
Lung & Bronchus	98,620	15%	70,880	26%
Colon & Rectum	74,630	11%	26,180	10%
Uterine Corpus	39,080	6%	7,400	3%
Non-Hodgkin Lymphoma	28,990	4%	9,060	3%
Melanoma	26,030	4%	Not Reported	
Thyroid	25,480	4%	Not Reported	
Ovary	22,430	3%	15,280	6%
Kidney & Renal Pelvis	19,600	3%	Not Reported	
Leukemia	19,440	3%	9,470	4%
Pancreas	Not Reported		16,530	6%
Brain & Other Nervous Sys	Not Reported		5,590	2%
Liver & Intrahepatic Bile Duct	Not Reported		5,500	2%
All Sites	**678,060**	**100%**	**270,100**	**100%**

Excludes basal and squamous cell skin cancers and carcinoma *in situ* except urinary bladder

7

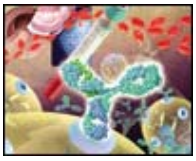
Cancer – Clinical Information

- **Risk Factors**
  - **Genetic factors:**
    - **Family history**
    - **Chromosomal abnormalities (e.g., Down Syndrome)**
  - **Environmental factors:**
    - **Cigarette smoking**
    - **Extended exposure to ultraviolet radiation**
    - **Diet**
    - **Exposure to chemicals such as asbestos**
    - **Geographic location**
    - **Virus (e.g., papillomavirus may cause cervical cancer, cytomegalovirus may cause Kaposi's sarcoma, hepatitis B may cause liver cancer)**

8

Cancer – Clinical Information

- **Tumor antigens – foreign substance recognized and targeted for destruction by the body's immune system**
- **Tumor markers – antigens released into the bloodstream by certain cancers which can be detected by blood tests**
  - **Not accurate enough to use as a screening tool**
  - **Determines if cancer treatment is effective**
    - **If the tumor marker disappears from the blood sample, then the treatment has been successful**



9

Cancer – Clinical Information

Tumor Antigen	Cancer
Carcinoembryonic antigen (CEA)	Colon, breast, pancreas, bladder, ovary, cervix
Alpha-fetoprotein (AFP)	Liver, ovarian, testicular, pineal gland tumors
Beta-human chorionic gonadotropin (ß-HCG)	Cancer originating in placenta, testicular
Prostate-specific antigen (PSA)	Prostate
CA-125	Ovarian
CA 15-3	Breast
CA 19-5	Pancreatic
ß2-microglobulin	Multiple myeloma
Lactate dehydrogenase	Testicular

10

Cancer – Clinical Information

- **Screening**
  - **Identifies the possibility of cancer being present**
  - **Results of screening tests need to be confirmed or disproved with further examinations**
  - **Common screening tests:**
    - **Papanicolaou (Pap) test to detect cervical cancer**
    - **Mammography to detect breast cancer**
  - **Allows cancer to be diagnosed in early stages and prevents it from spreading**

11

Cancer – Clinical Information

- **Diagnosis:**
  - **Thorough history and physical examination**
  - **Ultrasound**
  - **Computed tomography (CT) scan**
  - **Magnetic resonance imaging (MRI)**
  - **Biopsy**

12

Cancer – Clinical Information

- **Staging**
  - **Tests to determine:**
    - **The specific type of cancer**
    - **Tumor's location**
    - **Tumor's size**
    - **If it has metastasized**
  - **Aids physicians in determining appropriate treatment plan**
  - **Determines prognosis**

13

Cancer – Clinical Information

- **Staging**
  - **Additional diagnostic tests performed that identifies if cancer has spread:**
    - **Liver scan**
    - **Bone scan**
    - **X-ray**
    - **CT scan**
    - **MRI**
    - **Ultrasound**
    - **Bone marrow biopsy**
    - **Lymph node biopsy**

14

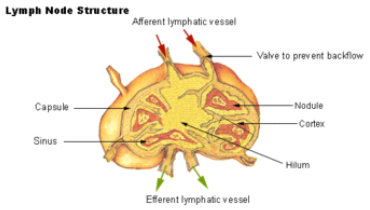
Cancer – Clinical Information

- **TNM staging system**
  - **T – extent of the primary tumor**
    - **TX means the tumor can't be measured or found**
    - **T0 means there is no evidence of primary tumor**
    - **Tis means the cancer is in situ (the tumor has not started growing into the surrounding structures)**
    - **The numbers T1–T4 describe the size and/or level of invasion into nearby structures**
      - The higher the T number, the larger the size of the tumor and/or the further it may have grown into nearby structures

15

Cancer – Clinical Information

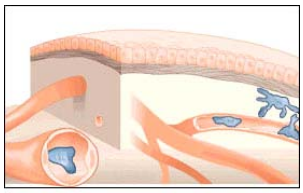
- **TNM staging system *continued***
  - **N – absence or presence of regional (nearby) lymph node involvement**
    - **NX means the nearby lymph nodes can't be measured or found**
    - **N0 means nearby lymph nodes do not contain cancer**
    - **The numbers N1–N3 describe the size, location, and/or the number of lymph nodes involved**
      - The higher the N number, the more involved the lymph nodes are



16

Cancer – Clinical Information

- **TNM staging system *continued***
  - **M – absence or presence of distant metastases**
    - **MX means metastasis can't be measured or found**
    - **M0 means there are no known distant metastases**
    - **M1 means that distant metastases are present**



Distant Metastases

17

Cancer – Clinical Information

- **TNM staging system *continued***
  - **Once the TNM is determined, an overall stage of I, II, III, or IV is assigned**
  - **May also be subdivided using letters such as IIIA and IIIB**
- **Dukes system for colorectal cancer may still be used by some physicians**
- **The stage of cancer does not change over time, even if the cancer progresses**
  - **A cancer that comes back or spreads is still referred to by the stage it was given when it was first diagnosed**

18

Cancer – Clinical Information

- **Treatment**
  - **Surgery – excision of the tumor from the body**
  - **Radiation – treatment with high-energy rays (such as x-rays) to kill or shrink cancer cells**
    - **Radiation may come from outside of the body (external radiation) or from radioactive materials placed directly in the tumor (brachytherapy or internal radiation)**
    - **Radiation therapy may be used as the main treatment for a cancer, to reduce the size of a cancer before surgery, or to destroy any remaining cancer cells after surgery**
    - **In advanced cancer cases, it may also be used as palliative treatment**

19

Cancer – Clinical Information

- **Treatment *continued***
  - **Radiation *continued***
    - **Admit for radiotherapy – V58.0**
      - Excludes: admitted for radioactive implant which codes to the condition
    - **Radiotherapy procedure codes:**
      - 92.20, Infusion of liquid brachytherapy radioisotope
      - 92.21, Superficial radiation
      - 92.22, Orthovoltage radiation
      - 92.23, Radioisotopic teleradiotherapy
      - 92.24, Teleradiotherapy using photons
      - 92.25, Teleradiotherapy using electrons
      - 92.26, Teleradiotherapy of other particulate radiation
      - 92.27, Implantation or insertion of radioactive elements
      - 92.28, Injection or instillation of radioisotopes
      - 92.29, Other radiotherapeutic procedure

20

Cancer – Clinical Information

- **Treatment** ***continued***
  - **Chemotherapy – treatment with drugs to destroy cancer cells**
    - **Chemotherapy is often used with surgery or radiation to treat cancer when the cancer has spread, when it has come back (recurred), or when there is a strong chance that it could recur**
    - **Admit for chemotherapy – V58.11**
    - **Chemotherapy procedure code – 99.25**
  - **Hormone Therapy – treatment with hormones, with drugs that interfere with hormone production or hormone action, or the surgical removal of hormone-producing glands**
    - **Hormone therapy may kill cancer cells or slow their growth**
  - **Targeted therapy – treatment that attacks some part of cancer cells that make them different from normal cells**

21

Cancer – Clinical Information

- **Treatment** ***continued***
  - **Biological therapy – substances that boost the body's immune system to fight against cancer**
    - **Also called biotherapy or immunotherapy**
    - **Drugs classified as biological response modifiers (BRMs) are:**
      - Aldesleukin (IL-2, Interleukin-2, Proleukin)
      - Epoctin (Erythropoietin, Epogen, Procrit)
      - Filgrastim (G-CSF, Neupogen)
      - Interferon alfa 2 (Roferon A, Intron, Wellferon, Alferon)
      - Levamisole hydrochloride (Erqumisol)
      - Opreleukin (Neumega)
      - Sargramostin (GM-CSF, Leukine)
    - **Admit for Immunotherapy (BRM) – V58.12**
    - **Immunotherapy procedure code – 99.28**

22

Polling Question #1

A patient with a diagnosis of vaginal wall recurrence from adenocarcinoma of uterus is admitted for intracavitary radiation of the vaginal wall.

What procedure code should be assigned on this case?

- ***1 Implantation or insertion of radioactive elements (92.27)**
- ***2 Radiation therapy, unspecified (92.29)**
- ***3 Chemotherapy (99.25)**
- ***4 Immunotherapy (99.28)**

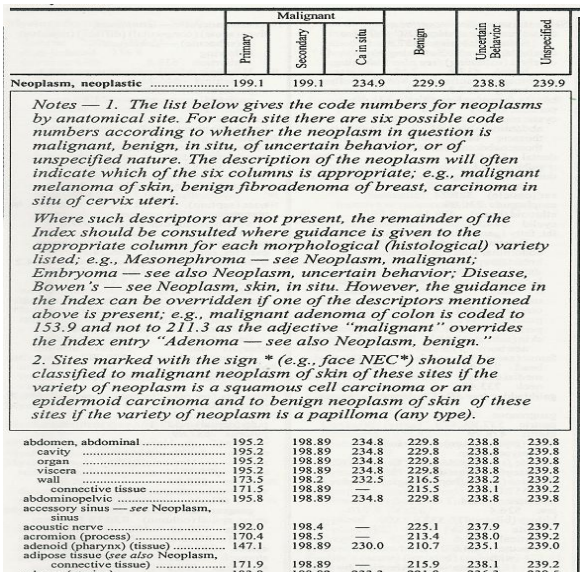
23

Coding of Neoplasms

- **Most neoplasm codes are located in Chapter 2 of ICD-9-CM (140-239)**
  - **Some benign neoplasm codes are located in the specific body system chapter**
    - **Example: Prostatic adenoma = 600.2x**
- **Reference the histological term first, if documented, in the Alphabetic Index before going to the Neoplasm Table and follow the instructional notes**
- **Refer to the Neoplasm Table in the Alphabetic Index in ICD-9-CM for appropriate code assignment**
  - **Provides the proper code based on behavior of neoplasm (e.g., malignant, benign) and site**
- **Always verify the code in the Tabular List**

24

Neoplasm Table



	Malignant					
	Primary	Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified
Neoplasm, neoplastic	199.1	199.1	234.9	229.9	238.8	239.9

Notes — 1. The list below gives the code numbers for neoplasms by anatomical site. For each site there are six possible code numbers according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior, or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate; e.g., malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri.

Where such descriptors are not present, the remainder of the Index should be consulted where guidance is given to the appropriate column for each morphological (histological) variety listed; e.g., Mesonephroma — see Neoplasm, malignant; Embryoma — see also Neoplasm, uncertain behavior; Disease, Bowen's — see Neoplasm, skin, in situ. However, the guidance in the Index can be overridden if one of the descriptors mentioned above is present; e.g., malignant adenoma of colon is coded to 153.9 and not to 211.3 as the adjective "malignant" overrides the Index entry "Adenoma — see also Neoplasm, benign."

*2. Sites marked with the sign * (e.g., face NEC*) should be classified to malignant neoplasm of skin of these sites if the variety of neoplasm is a squamous cell carcinoma or an epidermoid carcinoma and to benign neoplasm of skin of these sites if the variety of neoplasm is a papilloma (any type).*

abdomen, abdominal	195.2	198.89	234.8	229.8	238.8	239.8
cavity	195.2	198.89	234.8	229.8	238.8	239.8
organ	195.2	198.89	234.8	229.8	238.8	239.8
viscera	195.2	198.89	234.8	229.8	238.8	239.8
wall	173.5	198.2	232.5	216.5	238.2	239.2
connective tissue	171.5	198.89	—	215.5	238.1	239.2
abdominopelvic	195.8	198.89	234.8	229.8	238.8	239.8
accessory sinus — *see* Neoplasm, sinus						
acoustic nerve	192.0	198.4	—	225.1	237.9	239.7
acromion (process)	170.4	198.5	—	213.4	238.0	239.2
adenoid (pharynx) (tissue)	147.1	198.89	230.0	210.7	235.1	239.0
adipose tissue (*see also* Neoplasm, connective tissue)	171.9	198.89	—	215.9	238.1	239.2

25

Results Poll #1

A patient with a diagnosis of vaginal wall recurrence from adenocarcinoma of uterus is admitted for intracavitary radiation of the vaginal wall.

What procedure code should be assigned on this case?

- ***1 Implantation or insertion of radioactive elements (92.27)**
- ***2 Radiation therapy, unspecified (92.29)**
- ***3 Chemotherapy (99.25)**
- ***4 Immunotherapy (99.28)**

26

Behavior Classification

- **Malignant Neoplasm**
  - **Tumor cells that may extend beyond the primary site to adjacent structures or to distant sites**
  - **Two types of malignant neoplasms**
    - **Primary neoplasm: Localized point of origin**
    - **Secondary (metastatic) neoplasm: Site to which the tumor has spread**
      - May be described as extension, invasion, or metastasis

27

Behavior Classification

- **Carcinoma *in Situ***
  - **Tumor cells undergoing malignant changes but still confined to the point of origin without invasion of the surrounding normal tissue**
  - **Other terms included in carcinoma *in situ*:**
    - **Intraductal**
    - **Intraepithelial**
    - **Noninfiltrating**
    - **Noninvasive**
    - **Preinvasive**

28

Behavior Classification

- **Benign neoplasm: Not invasive and do not metastasize**
- **Neoplasm of uncertain behavior: No determination can be made if tumor cells are benign or malignant**
- **Neoplasm of unspecified nature: No specification of type or morphology of neoplasm**

29

Behavior Classification

The following sites are classified as secondary neoplasms when not otherwise specified:

- **Bone**
- **Brain**
- **Diaphragm**
- **Heart**
- **Lymph nodes**
- **Mediastinum**
- **Meninges**
- **Peritoneum**
- **Pleura**
- **Retroperitoneum**
- **Spinal cord**
- **Sites classifiable to 195**

Assign code 155.2 for malignant **neoplasms** of the **liver** that are not documented as either primary or secondary in nature

30

Neoplasm Coding Guidelines

1. **Designate the *malignancy* as the principal diagnosis when the treatment is directed toward the malignancy**
2. **Designate the *secondary site neoplasm* as the principal diagnosis when the treatment is directed *only* toward the secondary (metastatic) neoplasm even though the primary site is still present**
   - **If the treatment is directed equally toward both the primary and secondary sites, assign the primary malignancy as the principal diagnosis (*AHA ICD-9-CM Coding Handbook*, Faye Brown, 2004, page 300)**

***AHA Coding Clinic for ICD-9-CM*, 2006, 4Q, pp 161-164**

31

Neoplasm Coding Guidelines

3. **Follow these guidelines when coding complications associated with malignant neoplasms:**
   - **Sequence *anemia* as the principal diagnosis when the admission is for management of anemia associated with the malignancy or the therapy and the treatment is only directed at the anemia**
     - **Code assignment will depend on the specific type of anemia documented**
   - **Sequence *dehydration* as the principal diagnosis when the admission is for management of dehydration due to the malignancy or the therapy and only the dehydration is being treated**
   - **When the admission is for treatment of a complication resulting from a surgical procedure, sequence the *complication* as the principal diagnosis if treatment is directed at resolving the complication**

***AHA Coding Clinic for ICD-9-CM*, 2006, 4Q, pp 161-164**

32

Neoplasm Coding Guidelines

4. **When the primary malignancy has been previously excised or eradicated from its site and there is no adjunct treatment directed at that site and no evidence of any remaining malignancy at the primary site, use the appropriate code from category V10, Personal history of malignant neoplasm, to indicate the former site of the primary malignancy.**
   - **Documentation of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site**
   - **The metastatic site may be sequenced as the principal diagnosis if treatment is directed toward the metastatic site**

***AHA Coding Clinic for ICD-9-CM*, 2006, 4Q, pp 161-164**

33

Neoplasm Coding Guidelines

5. **Admission for treatment**
   - **Sequence the *malignancy* as principal diagnosis when the patient is admitted for surgical removal of a malignancy followed by chemotherapy or radiation therapy**
   - **If the patient is admitted solely for the purpose of receiving chemotherapy, immunotherapy or radiotherapy, sequence code *V58.11 (Admit for chemotherapy), V58.12 (Admit for immunotherapy), or V58.0 (Admit for radiotherapy)* as the principal diagnosis**

***AHA Coding Clinic for ICD-9-CM*, 2006, 4Q, pp 161-164**

34

Neoplasm Coding Guidelines

5. **Admission for treatment** ***continued***
   - **If the patient receives more than one of the therapies during the same admission, a *code will be assigned for each therapy performed* and *any of them* may be sequenced as principal diagnosis**
   - **Sequence *V58.0, V58.11, or V58.12* as principal diagnosis when the patient is admitted for radiation therapy, chemotherapy, or immunotherapy and complications develop due to the therapy**

***AHA Coding Clinic for ICD-9-CM*, 2006, 4Q, pp 161-164**

35

Neoplasm Coding Guidelines

6. **Sequence the *malignancy* (either the primary or secondary) as the principal diagnosis if the patient is admitted to determine the extent of the malignancy (staging) or for a procedure such as thoracentesis or paracentesis even though chemotherapy or radiation therapy is administered**
7. **Sequence the *malignancy* as principal diagnosis when the patient is admitted with signs and symptoms related to the malignancy**

***AHA Coding Clinic for ICD-9-CM*, 2006, 4Q, pp 161-164**

36

Neoplasm Coding Guidelines

8. **Sequence *a code from subcategory V50.4, Prophylactic organ removal*, as principal diagnosis if the patient is admitted for prophylactic removal of breasts, ovaries, or another organ**
   - **The prophylactic organ removal may be due to a genetic susceptibility to cancer or a family history of cancer**
     - **Assign codes for the genetic susceptibility and family history as secondary diagnoses as necessary**
   - **The prophylactic organ removal may be due to the patient having a cancer of a site and wants to prevent either a new primary malignancy at another site or a metastatic disease**
     - **Assign the malignancy as an additional code with a code from subcategory V50.4**
   - **Do not assign code V50.4x if the organ removal is for treatment of the malignancy**

***AHA Coding Clinic for ICD-9-CM*, 2006, 4Q, p 213**

37

Neoplasm Coding Guidelines

9. **Neoplasm related pain**
   - **Assign code 338.3, Neoplasm related pain, for a patient that has pain that is related to, associated with, or due to cancer (either primary or secondary) or tumor regardless if the pain is acute or chronic.**
   - **Code 338.3 includes:**
     - **Cancer associated pain**
     - **Pain due to malignancy (primary) (secondary)**
     - **Tumor associated pain**
   - **Code 338.3 is sequenced as the principal diagnosis if the reason for admission is for pain control/management**
     - **Assign a code for the malignancy as a secondary diagnosis**
   - **Code 338.3 may be sequenced as a secondary diagnosis if the reason for admission is for management of the neoplasm and the neoplasm related pain is also documented**

***AHA Coding Clinic for ICD-9-CM*, 2006, 4Q, p 171**

38

Polling Question #2

A patient with a history of breast cancer is now admitted with metastasis to the lung for partial pneumonectomy.

What diagnosis codes should be assigned on this case?

- ***1 Breast cancer (174.9) and secondary neoplasm of the lung (197.0)**
- ***2 Secondary neoplasm of the lung (197.0) and personal history of breast malignancy (V10.3)**
- ***3 Admit for chemotherapy (V58.11) and lung malignancy (162.9)**
- ***4 Lung malignancy (162.9) and personal history of breast malignancy (V10.3)**

39

Neoplasm Coding Directives

- **If a patient is admitted with a non-neoplastic condition for chemotherapy or immunotherapy, assign the *condition* as the principal diagnosis**
  - **Do not assign code V58.11 or V58.12**
  - **Example: Admitted for chemotherapy to treat macroglobulinemia**
    - **Assign code 273.3. Do not assign code V58.11**

  ***AHA Coding Clinic for ICD-9-CM*, 1995, 4Q, p 81 and 1992, 3Q, pp 5-7**
- **If a patient is admitted for radioactive implant, assign the *malignancy* as the principal diagnosis**
  - **Do not assign code V58.0**

40

Results Poll #2

A patient with a history of breast cancer is now admitted with metastasis to the lung for partial pneumonectomy.

What diagnosis codes should be assigned on this case?

- ***1 Breast cancer (174.9) and secondary neoplasm of the lung (197.0)**
- ***2 Secondary neoplasm of the lung (197.0) and personal history of breast malignancy (V10.3)**
- ***3 Admit for chemotherapy (V58.11) and lung malignancy (162.9)**
- ***4 Lung malignancy (162.9) and personal history of breast malignancy (V10.3)**

41

Lymphoma

- **Lymphoma is a group of malignant diseases which originates in lymph glands and other lymphoid tissue**
- **Lymphatic system is responsible for moving the lymph from the tissues to the bloodstream**
- **Lymphatic system mainly consists of:**
  - **Lymph nodes**
  - **Lymph vessels**
  - **Lymphatic ducts**
- **Lymphatic organs include:**
  - **Bone marrow**
  - **Spleen**
  - **Tonsils**
  - **Thymus gland**

42

Lymphoma

- **Types of lymphoma include:**
  - **Reticulosarcoma**
  - **Lymphosarcoma**
  - **Burkitt's lymphoma**
  - **Plasma cell lymphoma**
  - **Mixed lymphoma**
  - **Hodgkin's disease**
- **Signs and symptoms:**
  - **Painless swelling in the lymph nodes in the neck, underarm, or groin**
  - **Fevers and chills**
  - **Night sweats**
  - **Persistent fatigue**
  - **Weight loss**
  - **Enlarged spleen**
  - **Itching (pruritus)**

43

Lymphoma

- **Diagnosis:**
  - **Examination of the lymph nodes in the groin, underarm, and neck to check for swelling or lumps**
  - **Biopsy of lymph node**
  - **Blood and urine tests**
- **Diagnostic studies to confirm extent of involvement:**
  - **Chest x-ray**
  - **CT scan of abdomen and pelvis**
  - **Bone marrow biopsy**
- **Treatment:**
  - **Chemotherapy**
  - **Radiation therapy**
  - **Stem cell transplantation**

44

Lymphoma

- **Lymph node metastasis vs. lymphoma**
  - **Malignant neoplasm of the lymph node is presumed to be a metastatic site (category 196)**
  - **If documentation specifies that it is a primary lymph node malignancy, assign a code from categories 200-202**
- **Malignant neoplasms classified to categories 200-208 stated as secondary or metastatic remain within the 200-208 category range and are not coded to category 196**
- **If lymph nodes in more than one region of the body are involved, assign the fifth digit of 8**
- **Regardless of the number of sites involved, lymphoma is not considered metastatic**
- **Lymphoma patients who are in remission are still considered to have lymphoma and should be assigned the appropriate code from categories 200-202**

***AHA Coding Clinic for ICD-9-CM*, 1992, 2Q, p 3**

45

Common Neoplasm Related Questions

- **History of neoplasm still under treatment**
  - **Assign a code for the malignancy if a patient is receiving treatment (e.g., chemotherapy) for a malignancy that has already been excised or previously treated**
  - **Do not assign a code from category V10, Personal history of malignant neoplasm, because the patient would not still be under treatment if it were actually a history of malignancy**
  - **Example: A status post mastectomy patient is taking a chemotherapeutic medication for the breast cancer**
    - **Assign code 174.x. Do not assign code V10.3**

***AHA Coding Clinic for ICD-9-CM*, 1992, 3Q, p 7 and 1985, May-June, p 9**

46

Common Neoplasm Related Questions

- **Tamoxifen**
  - **Tamoxifen can be used for the treatment of breast cancer or for the prevention of breast cancer**
  - **Possible for patient to be maintained on tamoxifen for years after surgery**
  - **Assign a code from category 174, Malignant neoplasm of female breast, when a patient is receiving tamoxifen for the continuing treatment of primary breast cancer**
  - **If a patient was previously treated for primary site breast cancer (e.g., mastectomy, chemotherapy) and is now maintained on tamoxifen for the prevention of metastatic cancer, assign codes V58.69, Long-term (current) use of other medication, and V10.3, Personal history of breast cancer**

47

Common Neoplasm Related Questions

- **Tamoxifen *continued***
  - **If a patient with a strong family history of breast cancer is receiving tamoxifen prophylactically for the prevention of breast cancer, assign codes V58.69 and V16.3, Family history of breast cancer**

    ***AHA Coding Clinic for ICD-9-CM*, 2000, 2Q, pp 8-9**
  - **Review the record carefully to determine the reason the patient is being maintained on tamoxifen before assigning a diagnosis code**
  - **Cannot be automatically assumed that the patient is being treated for breast cancer simply because the patient is on tamoxifen**

48

Polling Question #3

A patient is admitted for a bilateral mastectomy. The patient wants prophylactic breast removal due to a strong family history of breast cancer.

What code should be sequenced as the principal diagnosis?

- ***1 Breast cancer (174.9)**
- ***2 Family history of breast malignancy (V16.3)**
- ***3 Status post surgery (V45.89)**
- ***4 Prophylactic breast removal (V50.41)**

49

Common Neoplasm Related Questions

- **Chemotherapy Induced Anemia**
  - **Assign code 285.9 for chemo-induced anemia unless a more specific type of anemia is documented**
  - **Code 285.22, Anemia in neoplastic disease, should not be used for this diagnosis**
  - **Per *Coding Clinic*, "Code 285.22 is for use for anemia that is due to the malignancy, not for anemia due to antineoplastic chemotherapy drugs, which is an adverse effect."**

***AHA Coding Clinic for ICD-9-CM*, 2006, 4Q, p 167**

50

Common Neoplasm Related Questions

- **Coding from Pathology Reports**
  - ***In the inpatient setting*, a code cannot be assigned from the pathology report alone without the physician confirming the diagnosis in the body of the medical record (e.g., progress notes or discharge summary)**
  - **If the pathology report lists a diagnosis that is not documented by the physician in the body of the medical record, then the physician should be asked if it is appropriate to add the diagnosis**
  - **Example: Lymph node metastasis is identified in the pathology report, and the physician does not document the diagnosis in the progress notes or discharge summary**
    - **Before assigning a code from category 196, the physician must document the diagnosis**

***AHA Coding Clinic for ICD-9-CM*, 2006, 1Q, pp 7-8 and 2004, 1Q pp 20-21**

51

Common Neoplasm Related Questions

- **Carcinomatosis**
  - **Widespread neoplastic growth throughout the body**
  - **If individual sites are documented, all sites should be coded separately**
  - **If carcinomatosis is documented without mention of specific sites, assign code 199.0, Disseminated malignant neoplasm without specification of site**

***AHA Coding Clinic for ICD-9-CM*, 1989, 4Q, p 10**

52

Results Poll #3

A patient is admitted for a bilateral mastectomy. The patient wants prophylactic breast removal due to a strong family history of breast cancer.

What code should be sequenced as the principal diagnosis?

- ***1 Breast cancer (174.9)**
- ***2 Family history of breast malignancy (V16.3)**
- ***3 Status post surgery (V45.89)**
- ***4 Prophylactic breast removal (V50.41)**

53

Resource/Reference List

- ***The Merck Manual of Medical Information Home Edition*, Merck Research Laboratories, 1997, pages 789-805**
- **American Cancer Society, www.cancer.org**
- **National Cancer Institute, www.cancer.gov**
- **AHIMA Web-based Coding Training**
  Oncology Services Coding in Hospitals
  http://campus.ahima.org/campus/course_info/CATS/CATS_newtraining.html#onc

54

Audience Questions

Audio Seminar Discussion

Following today's live seminar
Available to AHIMA members at
www.AHIMA.org

Click on Communities of Practice (CoP) – icon on top right
AHIMA Member ID number and password required – for members only

Join the Coding Community from your Personal Page then under Community Discussions, choose the
Coding Neoplasms Audio Seminar Forum
You will be able to:

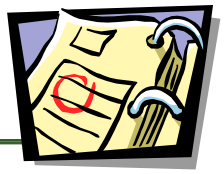
- Discuss seminar topics
- Network with other AHIMA members
- Enhance your learning experience

AHIMA Audio Seminars

Visit our Web site
http://campus.AHIMA.org
for information on the
2007 seminar schedule.
While online, you can also register
for seminars or order CDs and
pre-recorded Webcasts of
past seminars.

Continuing Education
Career-building Resources

Upcoming Audio Seminars



Reporting Hospital Outpatient Modifiers

- **May 3, 2007**

Coding for Gastrointestinal Endoscopy

- **May 10, 2007**

Notes/Comments/Questions

Thank you for joining us today!

Remember – sign on to the AHIMA Audio Seminars Web site to complete your evaluation form and receive your CE Certificate online at:

http://campus.ahima.org/audio/2007seminars.html

Each person seeking CE credit must complete the sign-in form and evaluation in order to view and print their CE certificate

Certificates will be awarded for AHIMA and ANCC Continuing Education Credit

Appendix

CE Certificate Instructions

AHIMA
Distance Education
Career-building Resources

To receive your

CE Certificate

Please go to the AHIMA Web site

http://campus.ahima.org/audio/2007seminars.html
click on
"Complete Online Evaluation"

You will be automatically linked to the CE certificate for this seminar after completing the evaluation.

Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.